CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050057	A. BUILDING: _____ B. WING: _____	07/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaweah Delta Medical Center	**400 W Mineral King Ave Visalia, CA 93291 TULARE COUNTY**

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	Complaint Intake Number: CA00609147 - Substantiated Representing the Department of Public Health: Surveyor ID # 39650, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of a facility. HEALTH AND SAFETY CODE SECTION 1279.1 (b) (1) (D) Retention of foreign object in a patient (b) For purposes of this section, "adverse event" includes any of the following: (1) Surgical events, including the following: (D) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained. California Title 22, Division 5, Chapter 1, Article 3: 70223(b)(2) Surgical Service General Requirement (b) A committee of the medical staff shall be assigned responsibility for: (2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professional and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.			

EVENT ID: D1NZ11 08/26/2019 4:32:03 PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 through 6
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on interview and record review, the facility failed to follow its policy and procedure to count items used for the insertion of a femoral (thigh) vascath (a tube or catheter inserted into large vein to filter and purify blood using a machine, also called hemodialysis) which resulted in the unintended retention of a guide wire for seven days for one sampled patient (Patient 1). Findings: During a review of the history and physical for Patient 1, it was noted Patient 1 was a 68-year-old female. She presented to the hospital emergency room on 10/15/18 with a chief complaint of weakness, chronic kidney disease (gradual loss of kidney function) and dizziness. Patient 1 was admitted to the hospital for medical treatment and emergency hemodialysis (a process to circulate and clean blood through a filter outside the body and then the blood is returned to the body). A vascath placement was urgently needed before hemodialysis could be performed. Patient 1 signed the surgical consent to have "VasCath placement for hemodialysis" on 10/15/18. Vascath is a specially designed catheter (catheter is a thin tube inserted into blood vessels to deliver fluids) that is inserted into a large vein such as femoral vein and can be used immediately for hemodialysis. In this type of surgical procedure, a guide wire, a wire, is inserted into an blood vessel to guide a catheter to a certain location in the body to effectively deliver hemodialysis. The guide wire is not intended to be left in after the procedure is completed. Leaving the guide wire inside a			

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	blood vessel could result in blood clots and/or infection. The Operative/Procedure note for Patient 1 was reviewed. The note was electronically signed by a Resident Physician (postgraduate training for qualified physician) on 10/15/18, at 11:11 PM, The post-procedure note indicated Resident Physician documented, "The guide wire was removed as the line was put in place...." During further review, it was noted a Supervising Physician (supervising physicians are responsible for making sure that patients seen by resident physicians receive the same caliber of care when working by themselves) added an addendum to this note on 10/16/18, at 12:43 PM, showed, "I saw and evaluated the patient with the resident (Resident Physician) and agree with the resident's findings." Neither the Resident Physician nor the Supervising Physician realized the guide wire was left in. The vascath, with guide wire inside, was used for hemodialysis for seven days, until 10/22/18. On 10/22/18, Patient 1 was scheduled for another central line catheter insertion for long term hemodialysis. The "Catheterization Procedure Report" for this procedure indicated: "a wire was found under fluoroscopy (a continuous X-ray image on a monitor) before the procedure began which was located in the superior/inferior vena cava (two large veins that carry blood to the heart) . . . Interventional Radiologist (IR, Interventional radiologists are doctors who are trained in radiology and interventional therapy) removed the wire from patient with snare (similar to a noose used to trap small objects)."			

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	During an interview with Resident Physician, on 10/24/18, at 3:25 PM, she stated she was on her second year residency program and did not require direct supervision from a supervising physician in central line insertion. Resident Physician stated her Supervising Physician was in the facility at the time of the procedure; but he was not at the bedside supervising her. Resident Physician described how the event occurred on 10/15/18. She stated while she was placing the vascath; a Registered Nurse (RN 1) informed her the vascath she just inserted was incompatible for hemodialysis. RN 1 brought the correct one for Resident Physician to use. Resident Physician stated, "I removed it (the first vascath) all including the guidewire." Then, she inserted the second vascath with triple lumen (three separate tubes combine into one tube) given by RN 1. Resident Physician stated after the insertion of the second one into Patient 1's femoral vein, she used the ultrasound (produces pictures inside body using sound waves) to check for placement of the catheter and did not see a guidewire. Resident Physician stated vascath insertion is an invasive procedure but "more like an IV (catheter placed in vein); therefore, no sharps counts are done." During an interview with the Assistant Chief Nurse Officer (ACNO) and a concurrent clinical record review, on 10/24/18, at 3:59 PM, ACNO was unable to provide documentation of instrument and sharp (needles) count prior to or after the vascath insertion. He stated there was no open cavity so no count was done. During an interview with Resident Physician,			

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	on 11/1/18, at 8AM, she stated she did not document the first vascath insertion procedure because she did not feel it was pertinent. During review of the clinical record for Patient 1, the Interventional Report, dated 10/23/18, indicated an ultrasound (sound waves that produce pictures inside the body) and fluoroscopy confirmed the presence of a retained intravascular (in the vein) wire which extended from the right internal jugular vein (neck vein) into the femoral vein (thigh vein). During an interview with IR, on 4/9/19, at 8:39 AM, he stated he performed an ultrasound and an x-ray on Patient 1 on 10/22/18 and removed the retained guide wire. He stated the guide wire he removed was the same size and type as in the three lumen vascath kit. The IR stated he had "no doubt" the guide wire was left in from the previous vascath insertion by error. The facility policy and procedure titled "Sponge, Instrument and Sharps" dated 2/16, indicated "Policy: A consistent multidisciplinary (several departments) approach for preventing retained surgical items will be used during all surgical and invasive procedures (medical procedure that enters body by cutting or puncturing the skin) . . .VI. SHARPS AND OTHER MISCELLANEOUS (sic) ITEMS: Sharps and other miscellaneous items must be counted on all procedures. This facility policy also referenced a project: "Gibbs, V. (2011). No thing left behind: Prevention of retained surgical items. Multistakeholder Policy. Retrieved from http://www.nothingleftbehind.org/ (an educational site intended for the use of			

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	healthcare organizations to prevent RSI (Retained Surgical Items)" indicated, "A retained device includes the entire unbroken item such as an intact guidewire inadvertently left in a central vein (which is the most common retained device) ..." The hospital staff failed to count a guide wire used during a vascath insertion procedure consequently had caused the unintended retention of a guide wire inside Patient 1's femoral vein for seven days. This failure had the potential to place Patient 1 at risk for infection or development of blood clots. These actions resulted in a non-immediate jeopardy adverse event.			